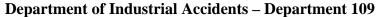
FORM 109

The Commonwealth of Massachusetts





DIA Board # (If Known):

NOTIFICATION OF WITHDRAWAL OF CLAIM OR COMPLAINT

DO NOT USE THIS FORM TO INDICATE CHANGE OF COUNSEL. PLEASE USE FORM 114 FOR THAT PURPOSE.

	3. Employee's Social Security Number*:
Employee's Address (No. and Street, City, State, Zip Code):	5. Employee's Telephone Number:
6. Name & Address of Employee's Attorney:	7. Telephone Number of Employee's Attorney:
	8. Date of Injury (mm/dd/yyyy):
11. Withdrawing From:	
Claim for Benefits	
Complaint for Modification or Discontinuance	
Complaint for Modification or Discontinuance Third Party Claim	
Third Party Claim Claim for Illegal Discontinuance	
Third Party Claim	